The Health of New Hampshire's Community Hospital System

A Financial Analysis

Memorial Hospital




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An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

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Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS[1]	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

[1] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[2]
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/ Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

[2] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire.*

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with $100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

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For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

MEMORIAL HOSPITAL, NORTH CONWAY, NEW HAMPSHIRE 1993 – 1999 FINANCIAL ANALYSIS

Memorial Hospital in Carroll County is an 35-bed acute-care facility and 45 beds in a nursing-home type-unit[3]. As of 1997, private insurers followed by Medicare represented the largest percentage of payers for inpatient discharges (39 and 35%, respectively)[4].

Memorial Development Foundation., Inc. is the nonprofit parent company of the hospital. MWV Healthcare Associates, a for-profit company that owns and manages physician practices, is the wholly owned subsidiary of the hospital. The hospital accounts for this subsidiary using the equity method.

Summary of Financial Analysis 1993-98

The financial performance of this hospital was strong over the six-year period, reflecting positive trends in profitability, liquidity and solvency measures. The hospital did not need to rely heavily on debt sources of capital and therefore has assumed little long-term debt. Plant age is a relatively young 7.7 years as of 1998. Financial health seems sustainable given the hospital's strong operating performance.

Cash Flow Analysis 1993-98

Most of the hospital's cash sources were internal. Net income alone generated half the total cash, and most of this was from operating income (37% of total cash sources), which illustrated that operating profitability drove the hospital's bottom line. Depreciation provided an additional one-third of the total cash. Increased long-term borrowing augmented internally generated cash and provided 12% of the total capital over the period.

Cash was spent mostly on investment in property, plant and equipment (PP&E), which represented 60% of total cash uses. This level of investment was twice the amount of depreciation expense over the period, and seems adequate given the relatively young age of plant of 7.7 years in 1998.

Almost one-third of the total cash generated was used to build cash balances. Twenty percent of the total cash was spent on increasing marketable securities and 10% reflected an increase in the cash account. As a result, the hospital was able to build substantial liquidity.

This pattern of cash sources and uses reflects good financial health. The hospital generates most of its cash from equity sources, a pattern that is sustainable given the hospital's strong and stable profitability. Its uses have improved its capital/fixed asset base and its cash position.

Ratio Analysis 1993-98[5]

Profitability

Profitability was strong, with total margins between 6-10% over the period. Operating profitability was the main driver of total margins. The operating margin declined from 1995 to 1996 because of slowed growth in the markup relative to the deductible. When the markup

[3] The 1998 American Hospital Association Guide.
[4] 1997 data from the State of New Hampshire Department of Health and Human Services.
[5] NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators.

recovered in 1997, so did the operating margin and it remained stable at 6% through 1998. The total margin was stable at 8%.

The hospital did not rely heavily on nonoperating activities for its bottom line because operating profitability was strong and stable. Nonoperating gains generally represented less than one-quarter of the total margins. Realized gains on the sale of investments represented a larger proportion of this contribution in recent years, but did not represent a significant portion of net income.

Liquidity

The hospital's liquidity is good and key measures improved over the period. The current ratio improved and shows that the hospital can easily meet its current obligations.

Working capital was managed well as illustrated by a steady collection period that was comparable to the state median at around 53 days. Additionally, the hospital maintained relatively speedy payments to vendors, as illustrated in the stable trend in the average payment period of around 35 days.

The hospital's liquid resources increased over the period. Days cash with short-term sources almost doubled over the period reaching 47 days as of 1998. Days cash with unrestricted marketable securities reached 144 days by 1998.

Capital Structure

The hospital has assumed little long term debt, even with its debt issuance in 1993 ($1.8M). Even in this year, the equity financing ratio (equity/total assets) illustrated that only about one-quarter of the hospital's assets were financed by debt capital (both short-and long-term sources). This ratio improved over the period as profitability remained strong and equity grew, improving the capitalization.

Because the outstanding debt is small and profitability is strong and stable, the coverage ratios are consistently very strong and demonstrate that the hospital had no problem covering its debt payments.

Charity Care and Community Benefits

Charity care reported as charges forgone ranged from 2.4 to 3.5% of gross patient service revenues over the period 1993 to 1998. This amount of charity care met the estimated value of the hospital's tax exemption in 1993. With the addition of 50% bad debt, the hospital met the estimated value of its tax exemption in all years except for 1994. This benchmark was met in 1994 when 100% bad debt was included.

The hospital did not report any additional community benefits in the footnotes to its financial statements.

In addition to charity care, the hospital operates a trauma center[1], which may be considered an additional charitable benefit to the community.

Cash Flow Analysis 1993 - 1999

Most of Memorial Hospital's cash sources were internal. Net income alone generated 46% of its total cash, and most of this was from operating income - 37% of total cash sources - which illustrates that operating profitability contributed significantly to the hospital's cash position. Depreciation provided an additional one-third of the total cash. Increased long-term borrowing augmented internally generated cash and provided 10% of the total capital over this period.

Cash was spent mostly on investment in property, plant, and equipment (PP&E), which represented 64% of the total cash uses. This level of investment was twice the amount of depreciation expense over the period. This seems adequate, given the relatively young age of the plant: 7.8 years in 1999.

Almost 30% of the total cash generated was used to build cash balances. Twenty-one percent of the total cash was spent on increasing marketable securities, and 7% reflected an increase in the cash account. As a result, the hospital was able to build substantial liquidity.

1999 Ratio Analysis

Profitability

Although the operating margin has declined from 6% in 1998 to 3% in 1999, the operating margin is still strong. It is at the 75th percentile of 1999 New Hampshire hospitals operating margins, and above the 1997 New England and national average operating margin. The operating margin declined in 1999 due to increased operating expenses. In 1999, non-operating gains represented 43% of the total margins.

Liquidity

The hospital's liquidity is consistent with the previous period. The current ratio improved slightly, from 4.56 in 1998 to 4.69 in 1999, and shows that the hospital can easily meet its current obligations.

The accounts receivable days have increased from 53.25 days to 55.48 days. Days of payments to vendors have decreased from 35 days in 1998 to 30 days in 1999. The days of accounts receivable is at the 25th percentile of New Hampshire in 1999 and was below regional and national averages for 1997.

The days of cash for short-term services decreased to 35 days in 1999 from 47 days in 1998. The days of cash with unrestricted marketable security also decreased to 132 days in 1999 from 143 days in 1998.

Capital Structure

The hospital has only $1.8 million of long-term debt. The long-term debt to equity ratio has reduced consistently from 0.20 in 1993 to 0.09 in 1999. The equity financing ratio of .82 is one of the most favorable among New Hampshire hospitals.

The debt service coverage ratio and debt service coverage ratio with operating income only were respectively 13.78 and 11.11 in 1999, compared to 14.61 and 12.95 in 1998. The hospital had no problem covering its debt payment.

Charity Care and Community Benefits
Charity care reported as charges forgone was 2.2% of gross patient service revenues in 1999. The bad debt charges were 4.5% of the gross patient service revenues.

The hospital did not report any additional community benefits in the footnotes to its financial statements.

Summary
The overall hospital performance is good. Its operating margin of 3% in 1999 is above 1997 regional and national averages, and is at the 75th percentile of New Hampshire hospitals in 1999. The liquidity and leverage ratio also demonstrated that the hospital is in a healthy financial position.

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health